Families at risk and the role of the care system

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DOI:
10.33612/diss.198180262

Chapter 8

General discussion

This thesis regards families at risk and the psychosocial care provided to them. More specifically, it focused on the role of family-related adversities in developmental outcomes of adolescents – both positive and negative. Next, it explored the role of parents in the psychosocial care for adolescents, and finally, it tried to understand the roles of mental health care providers in the care of adolescents. This final chapter summarises and discusses the main findings of the thesis. The methodological considerations of this study and its implications for practice and for future research are also discussed.

8.1 Main findings

Derived from the main aim of this thesis, we formulated five research questions. In this section we summarise the main findings per research question. The representations of the relations between these research questions can be found in Figure 8.1, at the end of this section.

Research question 1: Does family functioning mediate the association of family-related adversity with positive youth development?
We found that experiencing at least one family-related adversity was associated with lower scores on the Positive Youth Development (PYD) questionnaire. Moreover, we found that the following elements of family functioning were associated with PYD: 1) positive parenting and joint family activities contributed to better developmental outcomes and 2) poor parental supervision contributed to worse developmental outcomes. While positive parenting did not mediate the association of family-related adversity with PYD, joint family activities and poor parental supervision did mediate this association. Finally, we came to a serial mediation model: family-related adversity – poor parental supervision – joint family activities – PYD.

Research question 2: Does negative emotionality mediate the association of family-related adversity with positive youth development?
We did not find an association of family-related adversity with the first component of PYD (reflecting the development of the domains 'character' and 'caring'), but we did find an association of family-related adversity with the second component of PYD (related to the development of 'self'

and 'relationships'). Moreover, we found that experiencing negative emotionality, namely psychological distress, hostility and hopelessness, mediated the association of family-related adversity with the second component of PYD.

Research question 3: Does hopelessness mediate the association of family-related adversity with fighting?
We found that adolescents who experienced at least one family-related adversity were more frequently involved in physical fights. We further found that each specific family-related adversity, namely the death of a parent, parental substance abuse, violence between parents and divorce, was associated with more frequent involvement in physical fights. Moreover, we found that all associations of family-related adversities with fights were mediated by the hopelessness that adolescents experienced.

Research question 4: How do providers of psychosocial care for adolescents perceive the role of parents in psychosocial care for these adolescents?
Using a qualitative design, we found that psychosocial care providers perceived the role of parents in the care process in four ways. First, parents are a source of adolescents' problems; second, parents are trying to escape from responsibility for their child; third, parents are an active part of the care for adolescents; and fourth, parents represent a barrier to effective care.

Research question 5: How do providers of care perceive their professional roles in the care for adolescents?
In a discourse analysis, we identified three categories of roles for professionals working in child and adolescent mental health care (CAMH): those related to direct work with clients (expert, diagnostician, therapist), those related to cooperation with other professionals (participant in intra-institutional cooperation, participant in inter-institutional cooperation), and those related to the functioning of the institution (businessman). In the background of these roles, we identified nine discourses: biomedical, biopsychosocial, and psychotherapeutic discourses, and discourses of behaviourism, of humanism, of institutional care, of patients' rights, and of multi-disciplinarity and economic discourse.

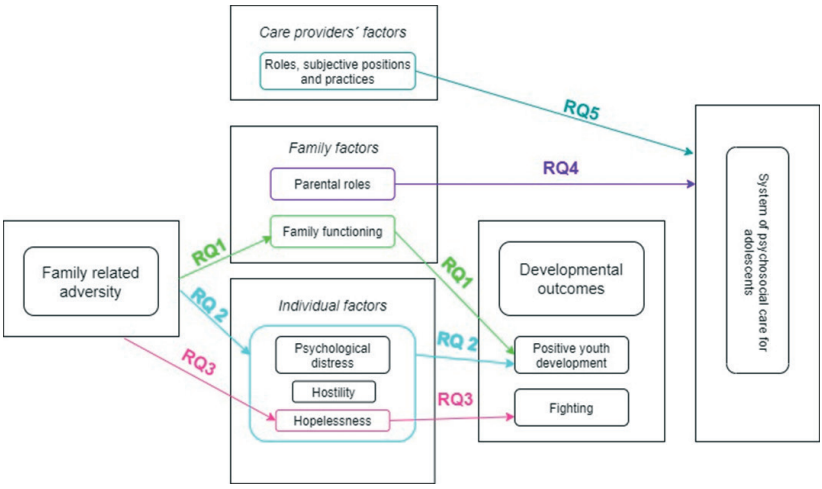

Figure 8.1 Relations between the research questions that have been addressed in this thesis

8.2 Discussion of the main findings

In the following paragraphs, we will discuss the main findings of this thesis within the framework of the general aims formulated in Chapter 1; see also Figure 8.1. First, we will discuss the association of family-related adversities with both positive and negative developmental outcomes in adolescents. Second, we will pay attention to factors on the individual level of adolescents and parental factors that play a role in this association. Third, we will focus on the role of parents in the psychosocial care provided to their children. Last, we will discuss how care providers perceive their own roles in the care and how this perception may affect the care that aims to help adolescents achieve better developmental outcomes.

8.2.1 Family-related adversities and developmental outcomes in adolescents

This thesis showed that family-related adversities are negatively associated with positive youth development (PYD) overall (Chapter 3) and with the domain of PYD connected to the development of the self and relationships (Chapter 4). These findings are in line with the literature: family-related adversities, such as divorce or separation of parents, the death of a parent, parental substance abuse and violence between parents, have been shown to be associated with a wide range of worse developmental outcomes in children and adolescents; e.g. a lower level of well-being (Amato & Afifi, 2006), lower self-esteem (Rangarajan & Kelly, 2006; Matsuura, Hashimoto & Toichi, 2009; Reddy, 2009), worse social competence (Hussong et al., 2005),

and involvement in violent dating relationships (Miller et al., 2011). We can explain these findings within the Attachment Theory of Bowlby (1969), which understands the relationship of a care giver and a child as a model for the future relationships of the child. Secure attachment in adolescence has been shown to be associated with a development of cognitive, social and emotional competence (Moretti & Peled, 2004). In this context we can expect family-related adversity to result in insecure attachment between parents and children, leading to deteriorated development in areas such as building and maintaining healthy relationships with other people. A second explanation of these findings is provided by the Theory of Social Learning (Bandura & Walters, 1977) and its revision The Social Cognitive Theory (Bandura, 1986). Parents serve as a model for different types of behaviour, and their children, via observational learning, conditioning and modelling learn how to behave. We can expect that parents who abuse alcohol or behave violently towards other persons have poor coping strategies for bearing difficult emotions and solving stressful situations. Thus, instead of developing healthy relationships, competencies and a healthy sense of self, children might learn these maladaptive strategies. Both theories assume that either parental behaviour or the parent-child relationship is a model for future development. However, based on our data, we cannot discriminate between these theories; therefore, we tried to understand our findings using both theories.

Next, we found that family-related adversities were connected to violent behaviour in adolescents (Chapter 5). This finding is in line with previous research showing that adversities experienced during childhood or adolescence were associated with a higher prevalence of emotional and behavioural problems (Lackova Rebicova et al., 2019; Theunissen et al., 2017) and different forms of violent behaviour (Mejia et al., 2006; Espelage et al., 2014; Finan et al., 2015, Fraga et al., 2016; Forster et al., 2020). As adolescents experience violent behaviour in their families, this violence can be "transmitted" to them from their parents as the intergenerational transmission of violence (Ehrensaft & Cohen, 2012; Widom & Wilson, 2015) describes. Similarly, as we explained above, vicarious, or in other words observational learning (Bandura & Walters, 1977; Bandura 1986), is the mechanism for children to learn behavioural patterns from their parents. This again highlights and supports the idea that observational learning plays an important role in how family factors affect developmental outcomes in adolescents. Not only the presence of violence in the family was found to be an important contributor to violent behaviour in adolescents.

We found that other family-related adversities, namely parental substances abuse, death of a parent and divorce of parents, were also related to more frequent physical fights in adolescents (Chapter 5). As research has shown, family-related adversities caused changes in the

neurodevelopment of the brain, e.g., in the development of impulse-control circuits (Hardee et al., 2014). This can also provide an explanation of why adolescents from such families tend to be involved in physical fights more often. In the case of parental substance abuse, research has shown that parents abusing drugs often experience difficulties in emotional regulation (e.g., Sher et al., 2007), and these difficulties can result in maladaptive coping strategies that adolescents can then learn, again by observational learning. Regarding the death of a parent, our finding is in line with previous research on bereaved adolescents, showing that such adolescents are usually at higher risk of being involved in health-risk behaviour, including physical fighting (Hamdan et al., 2012). Out of the explored family adversities, divorce had the weakest association with fighting, but this association was also found in previous research (Harland et al., 2002). Similarly as in the case of a parental death, we can expect that other family factors, such as poor family functioning (Chapter 3), may have played the important role in this association.

To summarise these findings, we found that experiencing family-related adversities was, on the one hand, associated with a deteriorated development of the PYD domains of connection, competence and confidence, and on the other hand, with more frequent violent behaviour. However, we did not find an association of the PYD domains 'character' and 'caring' with experiencing family-related adversities.

8.2.2 The mediating role of individual adolescent and parental factors

We found the associations of family-related adversity with both PYD and physical fighting to be mediated by factors at the level of the adolescent, i.e., hopelessness, psychological distress and hostility, as well as parental factors, i.e., poor supervision and family activities. First, we discuss the meditating role of psychological distress, hostility and hopelessness in the association of family-related adversity with the domains of PYD that specifically reflect development of the self and of relationships. This finding is in line with those of Strine et al. (2012) and of Wolff & Baglivio (2017), who also revealed negative emotionality to be a mediator between adverse experiences and developmental outcomes. An explanation for these findings can be provided by the Complex Trauma Theory. Complex trauma in children or adolescents is a result of repetitive exposure to severe stressors in caregiving. Moreover, as complex trauma often occurs within the caregiver system, the consequence is a disruption of the sense of self, experiencing anxiety and expecting the world to be unsafe and chaotic, which can in turn lead to the violation of relationships with others (Courtois & Ford, 2009; Cook et al., 2017).

Second, the mediating role of hopelessness in the association of family-related adversities with physical fighting has not been studied previously. However, by revealing the mediating role of hopelessness in

this association we support previous studies assessing the components of this mediation in parts, i.e., the association of family adversities with hopelessness (Haatainen et al., 2003), and the association of hopelessness with violent behaviour (e.g., Bolland et al., 2001; Bolland, 2003; Stoddard et al., 2011; Duke et al., 2011). Moreover, our finding can be explained within two theoretical frames. The first frame, Seligman's Theory of Learned Helplessness (Seligman, 1972), claims that uncontrollable trauma produces a sense of being powerless and the inability to change the situation. In the second frame, Abramson et al. (1998) described hopelessness as a result of learned helplessness. Adding to that, Bolland et al. (2005) described a phenomenon called "the process of abandonment of hope", which explains that adolescents are more likely to engage in violent behaviour if they believe that failure is an inevitable part of their future, and this explains why hopeless adolescents fight more often. We can find some similarities between these theories (the Complex Trauma Theory mentioned above and the Theory of Learned Helplessness); both assume that the child or adolescent is exposed to several stressors that he or she does not have enough skills or capacities to handle or change. One of our hypotheses is that the missing capacity may be emotional regulation. This hypothesis is supported by the findings of Anacker et al. (2014), who found that repeated exposure to stressful events can alter the ability to regulate oneself. Moreover, the importance of emotional regulation in the pathway leading from the emotional climate of the family (including attachment, parenting style, marital relations, expressivity), parenting practices (e.g., reaction to emotions in parents) and observational learning (including modelling, social reinforcing, emotion contagion) through emotional regulation to adjustment (represented by internalising, externalising behaviour, social competence and other outcomes), is described in the Tripartite model of the impact of the family on children's emotional regulation and adjustment (Morris et al., 2007). As we had not included all variables from this model in our study, we could not assess whether this indeed holds. However, emotional regulation is likely to be an important factor and should be considered in further research for a better understanding of this issue.

Regarding parental factors, we found that the association of family-related adversities with PYD was mediated by parental supervision and joint family activities. Our findings are in line with those of previous research exploring the mediating effect of parental monitoring in the association of parental and adolescents' substance abuse (Chassin et al., 1993). Important findings came from the study of Yamaoka & Bard (2019), which found that positive parenting practices might buffer the effect of adversities on the adolescent's development, but in case of insufficient parenting practices, these might be considered as another adversity. These findings underline the importance of parenting practices – they can buffer

the effects of adversities, or they can contribute to detrimental effects.

Next, this research also showed that joint family activities mediated the association of family-related adversities with PYD. This finding confirms previous studies that found positive effects of joint family activities on adolescents' psychosocial development (e.g., Offer, 2013; Windlin & Kuntsche, 2012). In our thesis, we further found a pathway leading from family-related adversity through poor parental supervision and family activities to PYD. First, in interpreting this finding, we must consider that adolescents were the primary source of our information, and they reported their own perspective on how much their parents supervised them and how much time they spent together. Next, we can interpret this finding in such a way that adolescents who experienced family-related adversity are less willing to share information with their parents, and therefore, they perceive that their parents are supervising them less. Both a higher perceived parental supervision and a higher willingness to disclose to parents have been associated with positive outcomes (e.g., Steinberg et al. 1995). Considering all together, we can conclude that parental practices and family activities should be involved in further studies with research focusing on assessing interventions for improving both of these.

To summarise, we have added to current knowledge that the association of family-related adversities with developmental outcomes are mediated by both individual factors (hopelessness, psychological distress, hopelessness) and parental factors (poor supervision and family activities).

8.2.3 Perceptions of professionals: Parents are often barriers to efficient psychosocial care, but they can also be facilitators of care

We explored how psychosocial care providers perceive the role of parents in the care of their children. We found that providers perceive parents mostly in a negative way (three of four identified ways, Chapter 6). Professionals perceive parents as a either the source of adolescents´ problems, a barrier to care or they highlighted the responsibility avoidance of parents. The idea of family being a source of adolescents' problems has been supported by previous research (e.g., Nanninga et al., 2015; Lackova Rebicova et al., 2019; Connoly & Kavish, 2019). Similarly, the theme of parents being a barrier to effective care for adolescents has been previously explored in the literature (Radovic et al., 2015; Kazdin, Holland & Crowley, 1997a; Kazdin, Holland, Crowley & Breton, 1997b). Probably the most surprising and insufficiently documented finding regarded the beliefs and experiences of psychosocial care providers that parents are trying to rid themselves of their responsibility for their offspring – they try to place adolescents in an institution or want to get their child "fixed"

without having to make any effort or cooperate themselves.

Our findings raise two important issues. First, such perceptions of professionals can *per se* be a barrier to effective cooperation with parents. Studies on this issue are rather rare. As one of the few, O´Sullivan & Russel (2006) described the cycle of blame, in which parents blamed professionals for not being supportive and professionals blamed parents for not being involved in the care. Radovic et al. (2015) brought similar perspectives, showing that providers indirectly blamed parents for being a barrier to care. Moreover, research has shown that parents have similarly negative perceptions of professionals and lack trust in them (Richardson, 2001). This knowledge points to the issue of how efficient cooperation of professionals and parents could possibly be in such a distrustful and blaming atmosphere. It implies a need to involve strategies about how to change these perspectives on both sides.

Second, we have tried to comprehend why parents are trying to escape their responsibility. One possible explanation is that these parents experience difficulties coping with their own problems. Support for this explanation is provided by the study of Owens et al., (2002) who found parents to be overwhelmed by the responsibilities of parenting and attending care as one of barriers. Moreover, Gordon et al. (2010) identified maternal depression as a factor related to missed appointments. The issue of parents being overwhelmed by their own problems and the problems of the family relates to the issue of multiproblem families, as children from such families were found to have a high risk of developing psychosocial problems and the whole family tends to become a multi-user of psychosocial care (Pannebakker et al., 2018). This indicates a need to work with whole families, especially if these face multiple problems. Further research is required, however, as according to the meta-analysis of Evenboer et al. (2018), it is not clear which interventions are effective and to what extent in providing care to multiproblem families.

Besides perceiving parents negatively, professionals also understood parents as essential actors in the whole process of providing care to adolescents. The findings of this thesis support previous research that brought evidence on the importance of the parental role in help-seeking behaviour (e.g., Hassett et al., 2018; Nanninga et al., 2015; Logan & King, 2006; Hoagwood, 2005; Zwaanswijk, 2003), including the ability to identify problems in their children (Glascoe & Dworkin, 1995) and in the recovery of adolescents (Kelly & Coughlan, 2019). To support an active parental role in the care, it is essential to create a good, collaborative relationship between professional and parent (Flicker et al., 2008; Hawley & Weisz, 2005) and to develop effective communication with both the parents and adolescents (Nobile & Drotar, 2003; Jager et al., 2015). To sum up, providers understand that parents are essential actors in the whole process of care. This implies a need for further research on effective strategies for how to

involve parents in care and establish good cooperation between parents and psychosocial care providers.

To summarise, we explored how psychosocial care providers perceive parents of the adolescents that are involved in care. We added to and supported the scarce literature on the issue of the perceptions of psychosocial care providers of parents. The most important finding regards providers' perceptions of parents as a barrier to care and blaming them for escaping from their responsibility, and the limited ability to collaborate with parents on solving the various issues. This is an important finding to be considered in the training and education of professionals.

8.2.4 The roles of care providers in mental health care for adolescents: which roles, subjective position and discourse of their background reflect the transformational tendencies of mental health care?

Besides professionals' perceptions of parental roles, we also explored how professionals working within child and adolescents' mental health care services (CAMHS) understand their own professional roles (Chapter 7). The current situation within CAMHS is changing, with new approaches focusing more on community-based and recovery-oriented services, and on the promotion of human rights in mental health care (Funk & Drew, 2017). In this section we discuss whether these changes within CAMHS are reflected by professionals' perceptions of their own roles, subjective positions taken within these roles and the discourses in the background.

We found three categories of CAMHS professionals' roles: first, those related to the direct work with clients (as expert, diagnostician, and therapist), second, those related to cooperation with other professionals (as participant in intra- and inter-institutional cooperation), and third, roles related to the functioning of an institution (as businessman). Within the roles related to direct work with clients in general, we found the biomedical discourse to be the most dominant discourse, supporting previous literature (e.g., Jørgensen, Praestegaard & Holen, 2020; Jacob, 2012; Zeeman & Simons, 2011). In the role of expert, this discourse led to the professionals' position of power over clients, enabling the belief that the professional can decide about clients and further treatments without involving the clients, and this also led to objectification and reduction of patients to symptoms. Similar findings were found in previous research (Kent, Cooke & Marsh, 2020; Coyne et al., 2015; Ziółkowska, 2012). Interestingly, we found that when the biomedical discourse collided with the discourse of patients' rights (represented by the need for patients' informed consent and patient participation), professionals found themselves in the position of helplessness and only reluctantly retired from their position of power and expertise. This unwillingness to give up the position of power can be explained by the concerns in care providers

that they would lose their responsibility for treatment (Bjønness et al., 2020).

Besides the biomedical discourse, the discourse of institutional care and behaviourism also led to a position of authority. This finding was not so surprising, as previous research showed that despite changes in the institutionalisation in psychiatry over time, the paternalistic relationships between professionals and patients remained as a stable trait of much of psychiatric care, as provided (Chow & Priebe, 2013). To add to that, LeFrançois (2007) summarised that children's participation rights in inpatient care were ignored within different countries, that children were controlled when receiving care from children's services and that their direct involvement in decision-making was limited (Coppock, 2002). The psychotherapeutic discourse, however, and the combination of this discourse with that of humanism enabled involving patients in decision-making, considering individual needs of patients, and emphasised the importance of the relationship between provider and client. The importance of a good relationship between professionals and clients has been confirmed previously (e.g., Shirk et al., 2011; Karver et al., 2008), similarly as the positive outcomes of patient-centred care in CAHMS (Kapp et al., 2017; Eldbrooke-Childs et al., 2016; Day, 2008).

Next, in the roles related to cooperation with other professionals (e.g., participant in the inter-institutional cooperation and participant in the inter-institutional cooperation), we identified the discourse of multidisciplinarity, the collision of the biomedical discourse with the discourse of patients' rights and the combination of the psychotherapeutic discourse with the discourse of patients' rights. From these, the discourse of multidisciplinarity resulted in practices such as networking and searching for an optimal solution for the client together with other professionals. The discourse of multidisciplinarity has been considered as a basic requirement in CAMHS (e.g., Bramesfeld et al., 2012), but it is not always successfully implemented (Dankulincova et al., 2020). One of the possible explanations why the multidisciplinary approach does not always work well is that regarding efficient multidisciplinary cooperation, the roles and competencies of individual professionals must be clearly defined (e.g., Suter et al., 2009). Surprisingly, the discourse of patients' rights and the need for informed consent was in this case described by professionals as a barrier in cooperation; when parents do not agree with involving another professional, they cannot proceed and stay in a passive position. Moreover, the discourse of patients' rights in some cases put professionals in the position of an individualist and contributed to an atmosphere of fear of sharing information with other care providers.

Our study also brought another important finding that is not frequently discussed in the expert discussion about transformation in CAMHS. We found that the role of businessman with the economic

discourse in the background, was related to setting barriers to the access to mental healthcare. Moreover, the role of businessman represented, first, a work burden, as professionals must spend time on marketing practices (Bramesfeld et al., 2012), and second, a psychological burden as professionals must accept limits from insurance companies that contrast with their beliefs about the best interest of clients. Next, the economic discourse caused the selection of clients such that low income could become a barrier to mental health care (e.g., Flisher et al., 1997). In other words, care providers had to choose between excluding clients unable to pay for treatment by themselves in exchange for gaining freedom in other factors of care (e.g., frequency and duration of therapy), or providing psychotherapy fully paid by the insurance company in exchange for limits from these companies and in the case of exceeding these limits, working for free.

To conclude, we found some discourses to be favourable for the aims of the transformation but others not. On the one hand, the biomedical discourses hindered attempts of transformation of CAMHS regarding the implementation of patient-centred care principles. On the other hand, the psychotherapeutic discourse combined with the discourse of humanism and the discourse of patients' right provided opportunities to implement these principles. Raising the multidisciplinarity discourse reflects these transformation attempts; however, a clear definition of the competencies of individuals within multidisciplinary teams is needed. Finally, the economic aspects of CAMHS need to be included in the transformation of CAMHS.

8.3 Strengths and limitations

This section provides a discussion of the strengths and limitations of this thesis. It covers three main topics: the quality of the sample, the quality of the information, and considerations regarding causality, which are discussed below. However, the general strength of this thesis is that we used both quantitative and qualitative study designs. On the one hand, in exploring associations of family-related adversity with developmental outcomes in adolescents we used quantitative data, as we needed to assess to what extent these associations can be generalised to some extent to the population of adolescents. On the other hand, trying to understand how professionals perceived their own roles and the roles of parents in care, we used qualitative designs that allowed us to explore these issues more deeply and to achieve a sufficient amount of in-depth information on the considerations of professionals.

8.3.1 Quality of the sample

In this thesis we reported five different studies that were based on four

samples. Regarding the methodology of these studies, three studies were quantitative and two were qualitative. In the following section, we will discuss the quality of each sample separately.

First, regarding quantitative data, we used two different samples, both having strengths and limitations. However, we believe that these samples together can provide a broader picture of the examined population of adolescents. We used a large national representative sample (Chapter 5) that allows us to make some generalised conclusions about the population of adolescents. The second sample, used in Chapter 3 and Chapter 4, covered adolescents aged 10 to 16 years and attending primary schools. Although this sample was not nationally representative, it represented adolescents coming from white, middle-income household. The primary schools involved in this study were randomly selected. Third, in Chapter 6 we used a sample of professionals working with adolescents. This sample covered care providers working in institutions in all three types of care (preventive-counselling, social and mental health care). As far as we know, we succeeded in covering this range of institutions. Therefore, we believe we have achieved insight in the full wide range of professionals' perspectives. Last, in Chapter 7 we used a sample of professionals working within mental health care for adolescents. The sample selection was designed to reach a heterogeneous sample of the main types of mental health care providers working with adolescents. During data collection, we reached a point of saturation, where no new themes occurred, so we believe that our sample provided a sufficiently rich spectrum of mental health care providers.

However, some limitations of the samples used in this thesis need to be mentioned. First, regarding the national sample of 13-year-old and 15-year-old adolescents (Chapter 5), we had to exclude some respondents due to incomplete questionnaires. This could have resulted in selection bias. Second, regarding the sample used in Chapter 4 and Chapter 5, the schools we involved in our study were attended mostly by children from families with middle or high socioeconomic status; therefore, findings from these two chapters could be generalised primarily on adolescents with similar socioeconomic background. Third, the sample used in Chapter 6 involved only four men, and the sample used in Chapter 7 included no men, but only women. However, it is not clear whether gender plays a significant role in the perceptions of professionals. Moreover, our selection reflected the real situation in psychosocial care, where mostly women work.

8.3.2 Quality of information

Regarding the quality of information in quantitative studies in general, we used both validated, internationally recognised instruments widely used by the Health Behaviour in School-aged Children research network

(HBSC) (e.g., see Roberts et al., 2009), and questionnaires adapted for the population of Slovak adolescents with good internal reliability. Regarding the quality of information in the qualitative studies, we used a qualitative design using semi-structured interviews that provide the opportunity to bring detailed insights in the examined issue. Another strength was our use of the principles of the Consensual Qualitative Research (CQR) methodology (Hill et al., 1977), which requires researchers to reach agreement on identified topics and interpretations. This was an important step to avoid subjectivity and to confirm that the topic is perceived correctly.

However, some limitations need to be mentioned as well. First, in Chapter 3, Chapter 4 and Chapter 5 we used self-reported data from adolescents, which may have led to some information bias due to the well-known phenomenon of social desirability. We tried to prevent this issue by using validated questionnaires and filling them out with trained research assistants and in the absence of a teacher in the research reported in Chapter 5, and with a trained care provider who had already developed a relationship with adolescent in the research reported in Chapter 3 and Chapter 4. In the qualitative studies, the analysis and interpretation of data may have been affected by subjectivity of researchers. This effect has been limited, however, as involving more researchers in the various stages improve intersubjectivity.

8.3.3 Causality

Regarding potential causal inferences, all of our quantitative studies had a cross-sectional design and therefore we cannot make conclusive statements about the causality of our findings. This implies that our findings need to be further examined, for instance, in longitudinal studies. Our thesis paid attention to confounding variables, and in all of our quantitative studies we controlled our analysis for gender, age and socioeconomic status. Our qualitative studies aimed to achieve deeper insight in selected topics (perceptions of care providers on the role of parents and their own professional roles in care) and had no aim to assess relationships or causality between variables.

8.4 Implications

8.4.1 Implications for practice and policy

This research has several important implications for practice and policy. First, we will discuss the implications of the findings coming from quantitative studies that explored the associations of family-related adversities with developmental outcomes and the mediating role of both individual and parental factors. We found that adolescents from families facing adversities, such as death of parent, parental substance abuse,

violence between parents or divorce of parents, were less developed in the PYD domains of connection, competence and confidence. Moreover, these adolescents reported more frequent involvement in violent behaviour. This implies that adolescents from families facing adversities need to be recognised as a high-risk group. This points to the need to identify such adolescents and provide them with activities and intervention aimed at creating more and better connections with others and on developing competence and confidence, but also strategies aimed at prevention and the reduction of violent behaviour. i.e., promoting safety in the family environment.

Next, we found that the association of family-related adversities with PYD was mediated by hopelessness, hostility and psychological distress, and the association of family-related adversities with physical fighting was mediated by hopelessness. If causal, this implies a need for interventions, and counselling these adolescents should help them to process these feelings. For examples, the study of Marques et al. (2011) showed that a hope-based intervention for students was effective in increasing experienced hope, self-worth and life satisfaction. Moreover, interventions aimed at self- regulation (including emotional regulation) have been shown to be effective in adolescents and have a positive impact on social skills, mental health, reducing behavioural problems and conduct disorders (Pandey et al., 2018).

Besides implications for working with adolescents, our findings also have implications for professionals' practice with parents. We found that adolescents experiencing family-related adversities also perceived less parental supervision and joint family activities, and that this related to a deteriorated development in the PYD domains of connection, confidence and competence. This indicates a need to include interventions aimed at supporting parents in providing an adequate level of supervision and to support parents in creating space for joint family activities. Relevant for implementing this are the findings of the meta-analysis of Chen & Chan (2016) showing that parenting programmes are effective in reducing the maltreatment of children and the study of Stallman & Ralph (2007) showing that an intervention aimed at enhancing parenting skills led to a decrease in adolescent behavioural problems. This provides cues for enriching further care.

Next, we discuss implications derived from the findings of the qualitative studies as reported in this thesis. We found that providers perceive parents in four different ways: as a source of the adolescents' problems, as people who are trying to escape responsibility, as a barrier to care and as an active part of a care. These findings may have several implications. First, professionals need education, training and guidance with interventions and approaches that can be used effectively in working with multiproblem families. Next, professionals need space to freely talk

about the negative experiences, attitudes and frustration coming from the difficulty of their work, e.g., also as part of inter-collegial exchange and intervision. This could help them find ways of dealing with such experiences and achieving better, less biased care. Third, as providers understand the importance of an active parental role, the enhancement of patient-centred care principles is needed. This may help to involve parents more actively in the care process. Moreover, professionals need to be supported in developing skills that will help them to communicate and cooperate with parents more effectively.

Lastly, we found some discourses to be favourable for the aims of transforming youth care and support, whereas other were not. On the one hand, the biomedical discourses hindered attempts to transform CAMHS towards the implementation of patient-centred care principles. On the other hand, the psychotherapeutic discourse combined with the discourse of humanism and the discourse of patients' right provides opportunities to implement these principles. Raising a multidisciplinarity discourse reflects these transformation attempts; however, a clear definition of competencies of individuals within multidisciplinary teams is needed. Finally, the economic aspects of CAMHS need to be included in this discussion. Based on these findings, we also have several suggestions. First, there is a need to increase the acceptance and development of the discourse of patients' rights and to implement patients' rights into the biomedical discourse. We believe this might support the involvement of patient-centred care practices into the daily practise of professionals working within CAMHS. Regarding the multidisciplinary cooperation of professionals, the findings from our study imply that there is a need to define roles and competencies of different professionals working with adolescents within CAMHS, as the multidisciplinary approach requires a clear definition of each professional and the person responsible for the coordination of multidisciplinary care. Regarding the economic discourse within CAMHS, an important issue is the exclusion of clients unable to pay. This may imply the need for a debate on changing the financing of CAMHS. Insurance should also cover treatment for patients without a diagnostic label, and this will allow care to be provided in a more supportive and approachable way.

8.4.2 Implications for future research

The findings of this thesis also have several implications for future research. Similarly as in the previous section, we will first introduce the implications based on the findings of the quantitative studies assessing the associations of family-related adversities with PYD and violent behaviour and the mediating role of individual and parental factors in these associations. In general, our findings need to be confirmed in larger, representative and preferably longitudinal studies. Further

studies should include adolescents coming from low-income households, as socioeconomic status may be an important variable. We found that family-related adversities were associated with deteriorated PYD and that this association was mediated by individual factors (hopelessness, psychological distress and hostility) and by parental factors (parental supervision and joint family activities). A longitudinal study could reveal whether and how these associations are causal.

We further found that family-related adversities were associated with more frequent fighting, and this association was also mediated by hopelessness. Longitudinal research is again needed to assess the time-sequence and causality of these associations. Next, we used the Tripartite model of family impact on children's emotion regulation as a support for our interpretation and understanding of the findings. This requires further study and could imply including emotion regulation as an important variable for further studies and assessing the relations of all variables (e.g., family-related adversities, individual factors, parental factors and developmental outcomes), i.e., making a more comprehensive model.

The findings from our qualitative studies may have some implications for further research, too. First, since we found that parents were important actors in the process of care, further research should also bring evidence on the strategies which professionals use to involve parents in care. These strategies should be then evaluated with the aim of identifying those that are effective. Second, as in our thesis we assessed only the current state of affairs in CAMHS, there will be a need to conduct research after some time has passed and assess how these transformational tendencies have been applied. Third, regarding the perception of professionals on their own roles and understanding these roles within the transformation of CAMHS, identification of strategies that can improve the implementation of patient-centred care principles, a multidisciplinary approach and changes in CAMHS financing is needed. After such identification, selected strategies should be evaluated.

8.5 Conclusions

To conclude, our findings add to the understanding of how family-related adversities are connected to both positive and negative developmental outcomes by examination of possible mediators both on the individual and parental level. Our findings brought evidence on the mediating effect of both individual adolescent (psychological distress, hostility and hopelessness) and parental factors (parental supervision and joint family activities) in the association of family-related adversities with developmental outcomes.

This thesis also adds knowledge about how psychosocial care

providers perceive their own roles and the roles of parents. Regarding care provider's perceptions of the roles of parents, we add to the understanding that professionals perceived the parental role in care predominantly in a negative way, as a source of adolescents' problems, as a barrier to care or as parents trying to avoid their own responsibility. Finally, positive perceptions on an active parental role in the whole process of care were also found, and professionals understood that parents can be very helpful, but they need to find strategies for how to approach and involve them successfully.

Regarding the perceptions of professionals on their own roles, we summarised professionals' roles in three categories: these related to direct work with clients, to cooperation with other professionals, and to the functioning of an institution. In the background of these roles, nine different discourses were identified. The biomedical discourse presented a barrier, while the discourses of multidisciplinarity, psychotherapeutic with the combination of the discourse of humanism and the discourse of patients' rights provide a space and opportunity for implementing a transformational process. Finally, we observed a need to include a consideration of the economic aspects of CAMHS into the transformational process.

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